TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BAYLOR SURGICAL HOSPITAL AT TROPHY CLUB

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-18-2192-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
February 23, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are requesting 130% of the Medicare allowable with implant reimbursement."

Amount in Dispute: $4,885.13

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Code C1765 is defined as an adhesion barrier. The invoice submitted by the requestor describes the substance billed with C1765 as a frozen liquid allograft. The operative report refers to it as '1ml allograft augmentation tissue . . . ' (1ml means one milliliter, the measurement of a liquid). As a frozen liquid it is neither an object nor device and thus, does not constitute a reimbursable implant. No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 7, 2017	Outpatient Hospital Services	$4,885.13	$4,885.13

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. Texas Insurance Code §1305.153 sets out payment provisions regarding network and non-network providers.
4. The requestor is a non-network provider that rendered pre-approved services to a network claimant in accordance with Texas Insurance Code §1305.153(c), which requires that out-of-network providers shall be reimbursed as provided by the Texas Workers' Compensation Act and division rules.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - A09 – DWC RULE DEFINITION OF IMPLANTABLES DOES NOT ENCOMPASS BIOLOGICALS; BIOLOGICALS AREN'T PAID AS IMPLANTALBES PER CH 134 DWC RULE & MEDICARE
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT
   - 16 – CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.

- 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- 217 – THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE.
- 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
- 305 – THE IMPLANT IS INCLUDED IN THIS BILLING AND IS REIMBURSED AT THE HIGHER PERCENTAGE CALCULATION.
- 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
- 725 – APPROVED NON-NETWORK PROVIDER FOR TEXAS STAR NETWORK CLAIMANT PER RULE 1305.153(C).
- 768 – REIMBURSED PER O/P FG AT 130%. SEPARATE REIMBURSEMENT FOR IMPLANTABLES (INCLUDING CERTIFICATION) WAS REQUESTED PER RULE 134.403(G)
- 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE
- 892 – DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRIPTIONS/INSTRUCTIONS.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the recommended payment for the services in dispute?
3. What is the additional recommended payment for the implantable items in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied billed implantable item C1765 with claim adjustment reason codes:
   - A09 – DWC RULE DEFINITION OF IMPLANTABLES DOES NOT ENCOMPASS BIOLOGICALS; BIOLOGICALS AREN'T PAID AS IMPLANTABLES PER CH 134 DWC RULE & MEDICARE
   - 16 – CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
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   - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
   - 892 – DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRIPTIONS/INSTRUCTIONS.

   The respondent argues:

   > Code C1765 is defined as an adhesion barrier. The invoice submitted by the requestor describes the substance billed with C1765 as a frozen liquid allograft. The operative report refers to it as '1ml allograft augmentation tissue . . . ' (1ml means one milliliter, the measurement of a liquid). As a frozen liquid it is neither an object nor device and thus, does not constitute a reimbursable implant.

   Per Rule §134.403(b)(2), "implantable" means an object or device that is surgically: (a) implanted, (b) embedded, (c) inserted, (d) or otherwise applied, and (e) related equipment necessary to operate, program and recharge the implantable.

   The disputed item is described on the invoice as "Celera Frozen Liquid Allograft" and in the operative report as "allograft augmentation tissue." Although, as a liquid, the item does not meet the definition of an "object" under the definition of an implantable in the division's Hospital Fee Guideline, it may still qualify if it is a "device."

   HCPCS code C1765 "adhesion barrier" is a Medicare "device category" code defined per Medicare payment policy as "a bioresorbable substance placed on and around the neural structures, which inhibits cell migration (fibroblasts) and minimizes scar tissue formation." The device definition does not require the barrier to be a solid substance.

   The respondent did not present any information to support the assertion that implantables do not encompass biologicals. In fact, the division notes, for example, that Medicare device category codes C1762 (human connective tissue) and C1763 (non-human connective tissue) are defined to include a range of biological substances such as "natural, cellular collagen or extracellular matrix obtained from autologous rectus fascia, decellularized cadaveric fascia lata, or decellularized dermal tissue," as well as "natural, acellular collagen matrix typically

obtained from porcine or bovine small intestinal submucosa, or pericardium." Because Medicare payment policies regarding implanted device category codes do clearly encompass biological materials, the insurance carrier's denial reason code A09, regarding implantables not encompassing biologicals, is not supported.

Review of the operative report finds the disputed item was noted as inserted or applied with the purpose to "promote tendon healing, encourage tissue regeneration, prevent adhesion formation, and decrease inflammation." The division thus finds the operative report sufficiently documents the disputed item's use as an adhesion barrier consistent with Medicare's definition of the device code. As such, the item is a surgically implanted device and therefore meets the requirements to be an "implantable" in accordance with the definition in Rule §134.403(b)(2).

The insurance carrier's other denial reasons are also found to be without merit. The division concludes this item is separately payable and will thus be reviewed for reimbursement in accordance with Rule §134.403(g).

2. This dispute regards outpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.403, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount (including outlier payments) applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors, as published annually in the Federal Register, with modifications set forth in the rules. Medicare OPPS formulas and factors are available from the Centers for Medicare and Medicaid Services at http://www.cms.gov.

   Review of the submitted information finds the provider requested separate payment for implants. Accordingly, per Rule §134.403(f)(1)(B), the facility specific amount (including outlier payments) is multiplied by 130 percent. Per Rule §134.403(f)(2), when calculating outlier payments, the facility's total billed charges shall be reduced by the billed charges for any item reimbursed separately under Rule §134.403(g). The charges for payable implants total $4,948.80. The total billed charges are thus reduced by this amount when calculating outlier payments.

   Medicare assigns an Ambulatory Payment Classification (APC) to OPPS services based on billed procedure codes and supporting documentation. The APC determines the payment rate. Reimbursement for ancillary items and services is packaged with the APC payment. CMS publishes quarterly APC rate updates, available at www.cms.gov.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure code 24359 has status indicator J1, denoting packaged services paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure (except those with status indicator F, G, H, L or U; certain inpatient and preventive services; ambulance and mammography). This code is assigned APC 5113. The OPPS Addendum A rate is $2,438.34. This is multiplied by 60% for an unadjusted labor-related amount of $1,463.00, which is multiplied by the facility wage index of 0.9794 for an adjusted labor amount of $1,432.86. The non-labor related portion is 40% of the APC rate, or $975.34. The sum of the labor and non-labor portions is $2,408.20. The cost of services does not exceed the thresholds for outlier payment. The Medicare facility specific amount of $2,408.20 is multiplied by 130% for a MAR of $3,130.66.
   - Procedure codes J1100, J1885, J2250 and J3010 have status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in payment for the primary services.

3. Additionally, the provider requested separate reimbursement of implantables. Per Rule §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission." Review of the submitted documentation finds the following implantables:

   - HCPCS code C1765 – "AMNIOTIC FLUID CELERA PU" as identified in the itemized statement and labeled on the invoice as "Celera Frozen Liquid Allograft, 1ML" with a cost per unit of $4,500.00;
   - HCPCS code C1713 "SUTURE ANCHOR KIT SONIC" as identified in the itemized statement and labeled on the invoice as "SONIC ANCHOR KIT 2.5X10 MM" with a cost per unit of $448.80.

   The total net invoice amount (exclusive of rebates and discounts) is $4,948.80. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $494.88. The total recommended reimbursement amount for the implantable items is $5,443.68.

4. The total recommended reimbursement for all disputed services is $8,574.34. The insurance carrier has paid $3,624.98. The requestor is seeking additional reimbursement of $4,885.13. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $4,885.13.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $4,885.13, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	March 23, 2018
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307.

A party seeking review must submit a Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (form DWC045M) in accordance with the form's instructions. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division, using the contact information on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.